EMPLOYER VERIFICATION OF INSURANCE COVERAGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53621 (01/2003)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

Instructions: Please complete Part A information and forward the form to your former employer to verify coverage in Parts B, C, D, and to sign Part E. These Parts must be completed by an authorized staff member of the employer. This information is used to determine eligibility for insurance provided through the North Dakota Public Employees Retirement System (NDPERS). This information must be returned to NDPERS accompanied by the applicable enrollment form(s).

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657

(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A	**EMPLOYEE AND EMPLOYER INFORMATION**
Employee Name (Last, First, Mi)	Social Security Number
Employer Name	Department Number (If applicable)
Date Employment Terminated	

PART B	**HEALTH INFORMATION**
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/ _____	
Does employee currently participate in the employer sponsored HEALTH plan? ☐ No ☐ Yes, Current level of coverage: _____	
Has employee been covered under COBRA? ☐ No ☐ Yes, If yes, Beginning date of COBRA: ____/ ____/ ____ Ending date of Health Coverage: ____/ ____/ ____	

PART C	**DENTAL INFORMATION**
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/ _____	
Does employee currently participate in the employer sponsored DENTAL plan? ☐ No ☐ Yes, Current level of coverage: _____	
Has employee been covered under COBRA? ☐ No ☐ Yes, If yes, Beginning date of COBRA: ____/ ____/ ____ Ending date of Dental Coverage: ____/ ____/ ____	

PART D	**VISION INSURANCE**
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/ _____	
Does employee currently participate in the employer sponsored VISION plan? ☐ No ☐ Yes, Current level of coverage: _____	
Has employee been covered under COBRA? ☐ No ☐ Yes, If yes, Beginning date of COBRA: ____/ ____/ ____ Ending date of Vision Coverage: ____/ ____/ ____	

PART E	**EMPLOYER CERTIFICATION**
Signature of Authorized Personnel	Date of Signature
Telephone Number:	